DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-14

2. STATE: Iowa

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 437.332; BIPA 2000 section 702

7. FEDERAL BUDGET IMPACT:
a. FFY 01 $ 0
b. FFY 02 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, pages 1, 1a, and 8

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, page 1 (MS-01-11) and page 8 (MS-98-7)

10. SUBJECT OF AMENDMENT:
Payment methodology for rural health clinics and federally qualified health centers

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Jessie K. Rasmussen

13. TYPED NAME:
Jessie K. Rasmussen

14. TITLE:
Director

15. DATE SUBMITTED:
3-26-01 March 28, 2001

16. RETURN TO:
Director
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
3/28/01

18. DATE APPROVED:

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN 1 2001

20. TYPED NAME:

21. TITLE:

22. DATE:

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Methods and Standards for Establishing Payment Rates for Other Types of Care

Rural Health Clinics (Cont.)

provided to enrollees. The payment to the center for these services is calculated as if the recipient was not an MCE enrollee (base rate plus adjustments times the number of visits) and the underpayment, if any, is paid to the rural health clinic. Such payments are made at least quarterly.

For a new center the Department will use an average of base rates paid to centers within the same geographic area performing the same or similar services as the first year base rate. The geographic area will be considered the current MCE rate setting region as determined by the Department.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Methods and Standards for Establishing Payment Rates for Other Types of Care

Federally Qualified Health Centers

X The payment methodology for federally qualified health centers will conform to section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA) legislation.

___ The payment methodology for federally qualified health centers will conform to the BIPA 2000 requirements Prospective Payment System.

X The payment methodology for federally qualified health centers will conform to BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:

1) is agreed to by the State and the clinic: and
2) results in payment to the clinic of an amount which is at least equal to the PPS payment rate .

The basis of payment for federally qualified health centers is reasonable cost, as determined by Medicare reimbursement principles in 42 CFR Part 413. Rates are developed on a retrospective cost-related basis and adjusted retroactively.

The Department uses the center's prior year Medicare cost reports to develop an interim rate to be paid for the current year that reflects payment for 100% of reasonable cost. (Until a center submits a cost report, the Iowa Medicaid Program makes interim payments to the center based on the amounts normally paid under Medicaid's fee schedule.)

Following submission of the Medicare cost report for the current year, the Department adjusts the interim rate for the coming year. Payments made over the supported costs are recovered. Adjustments owed to Medicaid must be made within 90 days following notice of the amount due. Any additional amounts supported by the Medicare cost report is paid to the federally qualified health center. Payment adjustments will be made within 90 days of receipt of the cost report.

The Department will compute the base rate which would be paid to participating federally qualified health centers under the prospective payment system considering any change in the scope of service applying all appropriate Medicare Economic Index increases. The Department will compute the center's FY 1999 and FY 2000 per visit rate for each clinic and will use an average of the two as the initial PPS base rate. This rate will be used to calculate the total payments that would be received under the prospective payment system methodology. This total will be compared to the total payment received for services under the methodology described above, and the state will pay the higher of the two.

Iowa Medicaid makes a supplemental payment to federally qualified health centers for people enrolled in a Medicaid-contracting MCE when the payment from the MCE is lower than the cost-based amount. Centers report all income from MCEs for Medicaid-covered services

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Methods and Standards for Establishing Payment Rates for Other Types of Care

Federally Qualified Health Centers (Cont.)

provided to enrollees. The payment to the center for these services is calculated as if the recipient was not an MCE enrollee (base rate plus adjustments times the number of visits) and the underpayment, if any, is paid to the federally qualified health center. Such payments are made at least quarterly.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Methods and Standards for Establishing Payment Rates for Other Types of Care

The following services are reimbursed on the basis of a fee schedule established by the Department following negotiations with representatives of the provider group involved plus periodic percentage increases based on the appropriate index.

- Ambulance services
- Area education agencies
- Audiologists
- Birth centers
- Chiropractors
- Clinics
- Community mental health centers
- Dentists
- Durable medical equipment dealers
- Family and pediatric nurse practitioners
- Family planning centers
- Hearing aid dealers
- Infant and toddler programs
- Lead investigation agencies
- Local education agencies
- Nurse midwives
- Opticians
- Optometrists
- Orthopedic shoe dealers
- Physical therapists in independent practice
- Physicians
- Podiatrists
- Psychologists
- Screening centers (EPSDT)
- Transportation to receive necessary medical care

*Substitute per letter dated 6/27/01

Ambulatory Surgical Centers and Independent Laboratories

The basis of payment for ambulatory surgical centers and independent laboratories is a fee schedule, as determined by Medicare.

Home Health Agencies and Rehabilitation Agencies

The basis of payment for home health agencies and rehabilitation agencies is reasonable cost on a retrospective basis. EPSDT private duty nursing and personal care services provided by a home health agency are reimbursed on an hourly basis using an interim fee schedule established by the Department. Vaccines for Children (VFC) is reimbursed on a vaccine administration interim fee schedule based on the physician fee schedule. EPSDT private duty nursing and personal care services and VFC services are retrospectively cost-settled.

Maternal Health Centers

The basis of payment for maternal health centers is reasonable cost on a prospective basis, as determined by the Department based on financial and statistical information submitted by the provider.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Methods and Standards for Establishing Payment Rates for Other Types of Care

Rural Health Clinics

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1) is agreed to by the State and the clinic: and
2) results in payment to the clinic of an amount which is at least equal to the PPS payment rate

The basis of payment for rural health clinics is reasonable cost, as determined by Medicare reimbursement principles in 42 CFR Part 413. Rates are developed on a retrospective cost-related basis and adjusted retroactively.

The Department uses the center's prior year Medicare cost reports to develop an interim rate to be paid for the current year that reflects payment for 100% of reasonable cost. (Until a center submits a cost report, the Iowa Medicaid Program makes interim payments to the center based on the amounts normally paid under Medicaid's fee schedule.)

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